471-000-90 Form MC-19,"Medical Assistance Provider Agreement" and Completion Instructions

Use: Form MC-19, "Medical Assistance Provider Agreement," is -

1. The required enrollment agreement between providers and the Nebraska Medical Assistance Program, also known as Nebraska Medicaid (See #7 regarding provider agreements for hospitals, dialysis centers, personal assistance providers, nursing and assisted living facilities.); and
2. The computer input document to establish each provider's computer files for payment; and
3. Required to be signed, approved, and on file with the Department before payment for covered services can be made.

Completion: The provider or the provider's authorized representative shall complete, sign, and date Form MC-19 as follows:

Please type or print legibly.

1. Check type of enrollment request:

   a. Check "New Provider Number" if you do NOT currently have a Nebraska Medicaid provider number.
   b. Check "Add Member To Group" if you are adding a group member- complete boxes 17, 18, and 21 on back of form
   c. Check "New FTIN Number" (tax number) if you have a provider number and require a new provider number because your tax ID number (FTIN) has changed.
   d. Check "Update Expired Provider Number" if your provider eligibility has expired.
   e. Current 11-Digit Provider Number: Enter current Nebraska provider number, if applicable.

2. Social Security Number: Enter the Social Security number and full name of the provider requesting enrollment. Complete this field only if enrolling as an individual/solo practice or if the provider in Field 5 does not have an applicable FTIN. If a Social Security Number is entered here, it will appear on the check and will be reported to the IRS if a W-2 or 1099 is issued at year end.

3. Federal Tax I.D. Number: Enter the FTIN of the provider requesting enrollment. Enter the name to whom the FTIN was issued. Enter the DATE the FTIN was issued, if available. The FTIN entered here will appear on the check and will be reported to the IRS if a W-2 or 1099 is issued at year end.

4. Check if any Provider Listed on the Agreement has been Suspended or Terminated from any Government Medical Program: Check Yes or No. If yes, provide name of person and government medical program and date suspended/terminated from that program.

5. Provider Name and Address: Enter the full name of the provider. When enrolling as an individual/solo practice, enter the individual provider's name AND title. When enrolling as a group practice, enter the group or clinic name. Enter the physical location address, city, state, zip code, and telephone number. Note: A post office box without a physical location address will not be accepted.

6. Pay to Name and Address (if different from 5): Complete only if payment will be made to a name and/or address other than identified in Field 5. A post office box is acceptable in this field.

7. Type of Provider : Enter the appropriate PROVIDER TYPE from the list below. (Required field) Choose only ONE.

Ambulance Service (Non-hospital)
Ambulatory Surgical Center-ASC
Audiologist
Ambulance Service (Non-hospital based)
Certified Alcohol and Drug Counselor
Certified Registered Nurse Anesthetist-C.R.N.A.
Chiropractor-D.C.
Community Mental Health Clinic
Dentist-D.D.S.
**Durable Medical Equipment/Medical Supply/Orthotic/Prosthetic Supplier
Federally Qualified Health Center-FQHC
Hearing Aid Specialist
*Home Health Agency
Independent Clinical Laboratory
Licensed Medical Nutrition Therapist-L.M.N.T.
Licensed Practical Nurse-L.P.N.
Magnetic Imaging Center
Medical Transportation (Non-ambulance)
MH/SA Community Support (MRO)
MH/SA Community Treatment Aide
*MH/SA Day Rehab (MRO)
*MH/SA Day Treatment
*MH/SA Residential Rehab (MRO)
*MH/SA Residential Treatment Center
*MH/SA Treatment Foster Care
*MH/SA Treatment Group Home
MH/SA Provider (Other)
Mental Health Therapist
Nurse Midwife
Advanced Practice Registered Nurse-A.P.R.N.
Occupational Therapist-O.T.
Optometrist-O.D.
Pharmacy
Physician-M.D.
Physician of Osteopathic Medicine-D.O.
Podiatrist-D.P.M.
Portable X-ray Service
Private Duty Nurse
Psychologist
Registered Nurse-R.N.
Registered Physical Therapist-R.P.1
Rural Health Clinic
Speech Pathologist
**Vision Care Supplier

*Home Health Agency and these identified Mental Health/Substance Abuse (MH/SA) providers proceed from this field to the "Terms of the Agreement" and signature on page 2 of the Agreement.

**Durable medical equipment suppliers indicate if enrolling for crossover (Medicare/Medicaid) claims only ("DME-CO only"). Durable medical equipment suppliers or vision care suppliers, enter the Medicare provider number in Field 9. Then proceed to the 'Terms of the Agreement" and signature on page 2 of the Agreement.

-Hospitals and dialysis centers use Form MC-20; nursing facilities use Form MC-81; assisted living facilities and personal assistance providers use Form MILTC-9.

7a. Primary Specialty: Enter the primary specialty. (Required field)

7b. NCPDP #: Enter the National Council for Prescription Drug Program (NCPDP) number issued to the provider identified in Field 5. (For pharmacy and dispensing physicians only). Enter date NCPDP number was issued.

8. License Number: Enter the license number, if applicable.

9. Medicare Number: Enter the Medicare provider number, if applicable.

10. NPI #: Enter the National Provider Identifier (NPI) number issued to the provider identified in Field 5. Enter date NPI number was issued. (Optional)

11. If laboratory services are provided, enter the CLIA number assigned to the provider identified in Field 5: Note: This is not required for optical laboratory services.

12. Mental Health/Substance Abuse Therapists and Counselors: All mental health/substance abuse therapists and counselors whose services require supervision must be enrolled with Medicaid as a group practice. The Provider Agreement must provide information regarding the individual therapist/counselor(s) and the supervising practitioner. Proceed to the GROUP PRACTICE information on page 2 of the Agreement. Note: Psychiatrists and clinical psychologists may enroll as a solo practice (see Field 14).

13. Pharmacy: Complete this section when requesting enrollment as a pharmacy. Check the box that best describes the type of pharmacy. Pharmacies do not need to complete box 14 or 15. Proceed to the "Terms of Agreement" and signature on page 2 of the Agreement.

14. Individual/Solo Practice: Check the appropriate practice description. (Do not check box 15 if checking this box.)

15. Group Practice: Check the appropriate practice description. (Do not check box 14 if checking this box.)

16. Check if you are Certified as: Check the appropriate certification, if applicable.

17-21. Complete applicable information.

17. Full Name & Title: Enter the full name and title of each group member.

18. License Number: Enter each group member's license number, if applicable.

19. Medicare Number: Enter each group member's Medicare number, if applicable.

20. NPI #:, Enter each group member's NPI number, if applicable.

21. Social Security Number: Enter each group member's social security number.

22 Sign Here: The provider or authorized representative/agent must sign and date the Provider Agreement, certifying the information is true, accurate and complete. A stamped signature will not be accepted. Enter the telephone number.

Failure to complete and sign this form and/or any requested updates shall be grounds to deny enrollment or to terminate any existing Provider Agreements under the Nebraska Medical Assistance Program. Note: Incomplete agreements will be returned.

NOTE: If information provided on this form changes, contact the Department of Health and Human Services Finance and Support, Medicaid Provider Enrollment at (402) 471-3121.

DISTRIBUTION: Return original copy to: Health and Human Services Finance and Support Medicaid Provider Enrollment P.O. Box 95026, Lincoln, NE 68509-5026

It is the provider's responsibility to retain a copy of the completed Agreement.